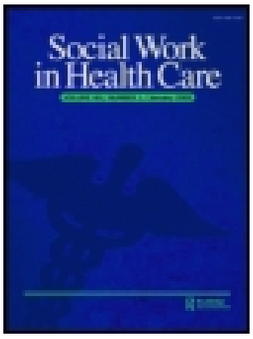

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One size does not fit all: differential transgender health experiences

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One size does not fit all: differential transgender health experiences

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ABSTRACT

Transgender and nonbinary (TNB) adults face a multitude of challenges when attempting to access general health care. Issues include fear of discrimination and encounters with providers who are not familiar with treating the needs of this population. These challenges may result in the delay or denial of medically necessary care. This study explores nuanced experiences of gender identity and sexual orientation around accessing health care. Using a statewide sample of TNB individuals (N = 417), analyses include descriptive statistics and logistic regressions predicting delayed care due to fear of discrimination and having any medical intervention to understand the importance of transgender-inclusive care and other experiences across identities. Findings indicate differential experiences across gender identity, sexual orientation, and age. Access to a trans-inclusive primary care provider was one of the strongest indicators both for not delaying care due to fear of discrimination and having had a medical intervention. Providers should be provided with more nuanced training about being culturally responsive and aware of differences across sexual orientation within the TNB community. This will move toward ensuring not only increased access to needed care and medical interventions, but toward potentially lowering the rate of those who delay access to care due to fear of discrimination.

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Transgender health; gender identity; health care; nonbinary; differential experiences

Transgender and nonbinary (TNB) adults face a multitude of challenges when attempting to access culturally responsive health care. Examples include issues of discrimination and encounters with providers who are not familiar with treating the needs of this population or may have misconceptions around these needs. However, little of the extant research has examined the differential health experiences of TNB across gender identity and sexual orientation. This study aims to explore these nuanced experiences, and to offer directions for new research as well as to underscore the urgent need for

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more training for trans-inclusive health care providers to support the needs of this community.

Transgender and nonbinary identities

Studies regarding gender in the U.S. have found that between 0.6% and 3.0% of American adults identify with a TNB gender identity (Herman, Flores, Brown, Wilson, & Conron, 2017.). An increasing number of youth and young adults are identifying as TNB with the current national estimates ranging from 0.7%–3.2% of those under 24 years old (Eisenberg et al., 2017; Herman et al., 2017; Wilson & Kastanis, 2015). More recently, a representative study of California youth found that 27.0% of 12- to 17-year-olds described their gender expression as gender nonconforming, of which 20.8% selected androgynous (Wilson, Choi, Herman, Becker, & Conron, 2017). Prevalence rates vary due to the rapidly evolving language of gender diversity and the individuality of gender identity (Frohard-Dourlent, Dobson, Clark, Doull, & Saewyc, 2017; Gates, 2014; Richards, Bouman, & Barker, 2017), but these studies indicate that numbers of this population continue to grow, particularly as these youth with more diverse gender identities transition into adulthood.

Gender diversity is a broad description for the umbrella terms transgender and nonbinary, referring to individuals whose gender identity does not align with the sex they were assigned at birth. The term transgender or trans encompasses an inclusive array of gender identities and expressions including those who medically transition and identify within the masculine/feminine binary (such as male-to-female and female-to-male individuals) as well as more fluid or expansive gender identities outside of this binary (Beemyn & Rankin, 2011a; Budge, Rossman, & Howard, 2014; Davidson, 2007). Alternatively, some individuals prefer labels under the nonbinary umbrella including nonbinary, genderqueer, genderfluid, bigender, and agender among numerous more (Harrison, Grant, & Herman, 2012). With recognition of these ongoing fluctuations in the community, the term TNB is used in this study as the most inclusive reflection of the growing diversity of gender identities.

TNB health

Historically, much of the health research on the TNB community was conducted primarily on HIV/AIDS risk factors and potential interventions (Arayasirikul, Wilson, & Raymond, 2017; Stieglitz, 2010), and/or rates of substance use within this community (Rowe, Santos, McFarland, & Wilson, 2015; Scheim, Bauer, & Shokoohi, 2017). Additionally, the majority of the research on transgender overall health among adults either compares rates of issues within the TNB

community against those of cisgender people (Reisner, White, Bradford, & Mimiaga, 2014), or explores rates of certain illness, diseases, and risk factors within the transgender community. While there is more research of TNB youth, and on TNB adults in the realm of mental health, there continues to be a dearth of studies exploring the general health of TNB adults. Few, if any, touch on the differential experiences of TNB individuals across gender identities within this population with broad gender categories concealing in-group differences (Cruz, 2014), and none explore the specific needs of nonbinary individuals when accessing health care, despite the call for more nuanced research in this area (Frohard-Dourlent et al., 2017).

Trans-inclusive providers and issues of discrimination

Gender identity related discrimination is prevalent in multiple settings and contexts, including employment, housing, educational settings, and public spaces such as restrooms (Kattari, Whitfield, Walls, Langenderfer-Magruder, & Ramos, 2016; Beemyn & Rankin, 2011a; James et al., 2016; Seelman, 2014; Stolzenberg & Hughes, 2017). Medical settings are not immune, with TNB individuals reporting elevated rates of being denied access to care, as well as experiencing verbal harassment and physical violence, while attempting to access doctors and hospitals, emergency rooms, and using ambulances/EMTs (Grant et al., 2011; James et al., 2016). TNB individuals may decline or delay seeking needed medical care due to their concerns about discrimination from providers (Bauer et al., 2009; Lewis, 2008). One study found that 61.0% of transgender participants had chosen to delay or completely avoid accessing medical care due to fear of gender identity related discrimination in health care settings (One Colorado Education Fund [OCEF], 2011). Currently, 31 states in the United States allow for discrimination regarding gender identity in employment, housing, and public accommodations such as restrooms (Movement Advancement Project, 2018). These experiences of health care discrimination are increased for TNB people of color and people with disabilities, and also vary across the life span (Kattari, Walls, Whitfield, & Langenderfer-Magruder, 2015, 2017; Kattari, Walls, & Speer, 2017). Specifically, (Kattari, Walls, Whitfield, & Langenderfer-Magruder, 2015) found that people of color experienced lifetime elevated rates of discrimination in comparison to their White peers at the doctor's office, the emergency room, and in ambulances or with EMT's. Multiracial participants reported the highest rates of discrimination at both the doctors office and the emergency room and Latino respondents experiencing the most elevated rates in ambulances and with EMT's (Kattari, Walls, Whitfield, & Langenderfer-Magruder, 2015).

Fear is not the only challenge faced by members of this population when accessing care. Many TNB people are forced into the role of educating their providers about the medical and emotional needs of TNB individuals, while

also correcting misinformation and combating stigma and bias. For example, one erroneous assumption is that all transgender individuals want to have surgeries while all nonbinary individuals do not want any type of medical intervention (Institute of Medicine [IOM], 2011; Keiswetter & Brotemarkle, 2010; OCEF, 2011; Poteat, German, & Kerrigan, 2013; Xavier, Bobbin, Singer, & Budd, 2005). Emerging findings suggest that not only is transgender-inclusive health care important in terms of transition-related care, but that it also may have a protective function. In one recent study, TNB individuals who reported having primary care practitioners who were "transgender inclusive" were significantly less likely to experience current depression or have had suicidal ideations in the past year (Kattari, Walls, Whitfield, & Langenderfer-Magruder, 2016).

In addition to research that replicates these findings with larger and more diverse samples, future research in this area needs to better understand who within the TNB communities has increased access to trans-inclusive providers, and more specifically, what ways in which to better train health providers to be affirming of this population. Some research has begun to emerge on this topic, indicating the need for more provider training on trans health related topics (both while in medical school and ongoing), creating built environments that feel more affirming to TNB individuals, offering resources to patients and clients that are also culturally responsive and trans-inclusive, clearer information on how to access care, and centering on the resilience of members of this population (Puckett, Cleary, Rossman, Mustanski, & Newcomb, 2018; Reisner et al., 2015; Torres et al., 2015).

Medical transitions

As part of transitioning in to their authentic gender, some TNB individuals (although certainly not all) pursue gender-affirming physical interventions, which can be categorized as reversible, semi-reversible, and permanent. Several examples of reversible options include changes in hairstyles, growth or removal of body hair, clothing, cosmetics, accessories, and weight lifting (Beemyn & Rankin, 2011b). Semi-reversible interventions include puberty blockers, hormone replacement therapy, and chest binding. Finally, surgical interventions are permanent interventions available for TNB individuals who decide to pursue such options. Hormone replacement therapy (HRT) and gender affirming surgeries are the two most common medical interventions selected by TNB individuals, and also interventions in which social workers may play a role, whether in writing a letter confirming the need for such an intervention, in connecting their clients to local providers offering these interventions, or in healthcare systems through case management or part of an interprofessional care team.

Hormone replacement therapy (HRT)

Semi-reversible interventions are an example which may have reversible effects or effects that stop with disuse. Among youth, hormone suppression or puberty blockers can reduce gender dysphoria in transgender youth considerably (Butler, 2017); however, the cost of puberty blockers may be a substantial barrier for many youth and their families. HRT can also be a pivotal point in one's transition (Beemyn & Rankin, 2011b), marked by noticeable physical changes that elicit recognition of one's gender. Although many nonbinary individuals do not pursue HRT (Yelland, 2017); of those who do, some seek low-doses of HRT (Seal, 2017). According to Yelland (2017), the expected results from HRT typically occur within the first year; however, this can vary by method (e.g., gel, patch, intramuscular injections) and dose.

Surgeries

Numerous surgical interventions exist with the most common being top (chest/breast) surgeries, bottom (genital) surgeries, and facial modifications. As chests are the primary source of dysphoria for many TNB individuals who are assigned female at birth (AFAB), top surgery can be a high priority and is more common than bottom surgery (Beemyn & Rankin, 2011b; Butler, 2017). Similar to AFAB individuals, breast augmentation can be a significant permanent change to increase the visibility of assigned male at birth (AMAB) individual's gender. Historically, more trans women seek bottom surgery than trans men; however, the frequency for transmen is increasing with improving surgical techniques (Ralph, Christopher, & Garaffa, 2017). According to Bellringer (2017), the majority of trans women pursue full genital reconstruction consisting of multiple extensive surgeries, but few studies offer more nuanced information on the percentages of those desiring such medical interventions. Those who do not pursue bottom surgery report it is due to prohibitive costs, older age, poor health, being unnecessary for affirming their gender, concerns about sexual functioning after surgery, and other life circumstances (Beemyn & Rankin, 2011b).

As trans health care is prioritized, TNB individuals have an increasing range of gender affirming interventions available to choose from. Assisting TNB individuals find the best for them without preconceived expectations of transitioning is necessary for affirming gender, especially nonbinary identities.

Education and training for trans-inclusive social workers

Despite an explicit professional code to advocate for marginalized populations, including the basis of gender identity and sexual orientation (National Association of Social Workers [NASW], 2017), many social workers are not trained to practice with TNB populations. Research has found a lack of trans-specific content (Erich,

Boutté-Queen, Donnelly, & Tittsworth, 2007; Floyd & Gruber, 2011; Logie, Bridge, & Bridge, 2007) and a presence of transphobia in social work education (Austin, Craig, & McInroy, 2016; Fredriksen-Goldsen, Woodford, Luke, & Gutierrez, 2011). Unsurprisingly, Social workers report not feeling prepared to effectively practice trans-affirmative care due to minimal knowledge or competency (Erich et al., 2007).

A mixed methods study (N = 97) of transgender social work students explored the perception of transgender issues in social work education and found barriers to trans-affirmative education to include a lack of trans-affirmative course content and faculty with expert knowledge, little attention given to transgender issues, and the presence of transphobic microaggressions (e.g., pathologizing trans experiences and trans erasure) (Austin et al., 2016). Notably, a study of U.S. and Canadian social work faculty (N = 327) showed that 40% of social work faculty in the U.S, did not believe trans-specific information was a priority in social work curriculum despite 73% (U.S. and Canada) strongly agreed that TNB people experience discrimination (Fredriksen-Goldsen et al., 2011).

A lack of trans-affirmative education has the potential implication for training social workers who are not knowledgable about TNB issues and whose biases about TNB individuals are not critically examined (Erich et al., 2007; Floyd & Gruber, 2011; Logie et al., 2007; Stotzer, Silverschanz, & Wilson, 2013; Wagaman, Shelton, & Carter, 2018). A review of the literature on TNB access to health care identified the following main barriers to accessing care: "1) experiences with discrimination or outright rejection from services; 2) provider insensitivity or poor treatment while receiving services; 3) problems or concerns with physical environment or 'climate' of social service agencies; 4) difficulty with availability of and accessing appropriate services; and 5) a lack of cultural competence in regard to transgender issues" (Stotzer et al., 2013, p. 67). A secondary analysis of data from the National Transgender Discrimination Survey (NTDS; Grant et al., 2011) found that 65% of the TNB sample (N = 5,981) experienced at least one form of gender-based discrimination, with 16% of the sample reporting this discrimination occurring in a social-service setting (Klein, Mountz, & Bartle, 2018).

Identifying and addressing the unique needs of TNB individuals and developing trans-affirmative care begins with education (Stotzer et al., 2013). To fill the identified gaps in social work education, findings from Austin et al. (2016) recommend infusing LGBTQ issues throughout social work education with explicit inclusion of trans-specific content (that is affirming and not pathologizing) as well as motivating faculty toward ongoing LGBTQ education beyond foundational knowledge. Stotzer et al. (2013) offer three recommendations. First, continued education and sensitivity training in trans-specific topics are essential for developing empathy, disrupting assumptions about gender, and increasing sensitivity and comfort in working with transgender clients. Agency and program changes are

also necessary for creating trans-affirmative practice including creating inclusive forms (e.g., providing more than binary gender options) and a representative environment (e.g. pamphlets, posters), as well as hiring TNB employees. Last, providing trans-affirming care requires critical assessment about appropriate care for TNB individuals in current programing as well as addressing gaps specific to the TNB community. Additionally, adopting a queer theoretical framework or queering social work education can help students and faculty to critically assess language and power, to challenge assumptions, disrupt the hetero/cisnormativity and center queerness, and create strategies for meaningful change (Wagaman et al., 2018).

Research question

Given the limited health research on TNB individuals by gender identity, we pose the questions; *1) Are sociodemographic characteristics, especially gender identity within the larger TNB umbrella, and access to a trans-inclusive health care provider correlated with delaying health care for TNB individuals?* and *2) Are sociodemographic characteristics, especially gender identity within the larger TNB umbrella, and access to a trans-inclusive health care provider correlated with undergoing transition-related medical interventions for TNB individuals?*

Methodology

Methods and procedures

Data for this study come from the 2014 Colorado Transgender Health Survey (N = 417), collected as a collaboration between the One Colorado Education Fund, The Colorado Department of Public Health and Environment (CDPHE), and The GLBT Center of Colorado (GLBT Center). Data were collected in 2014 via an online survey and in-person over a seven-month period. For online surveys, the partner organizations used Facebook and Twitter to promote the survey and individuals shared the survey link on their own social media sites as well as in transgender-focused forums. In-person surveys were gathered by outreach efforts throughout Colorado at colleges, universities, and LGBTQ-focused or -supportive organizations (e.g., health care centers, mental health providers, homeless shelters, support centers, and religious institutions). Additionally, the in-person survey was available at LGBTQ pride festivals throughout Colorado and at Colorado TNB specific conference. This study received institutional review board approval as secondary data analysis.

Measures

The measures were designed by those conducting the initial survey. Regarding sociodemographic characteristics, racial and ethnic identities were collected with a variety of response options (*White, Black/African American, Asian, Native Hawaiian or Other Pacific Islander, American Indian/Native American, Hispanic/Latino, Multiracial)*. Given the small percentage of respondents in many of the racial/ethnic groups, and that preliminary analyses conducted with each racial/ethnic group as separate identities showed no significant differences between these various groups, all racial/ethnic identities other than White were collapsed to examine differences between TNB People of Color and White TNB individuals. This resulted in two racial/ethnic categories (*White* and *People of Color*). Gender response options on the survey included *trans woman, trans man, transgender, man, woman, agender/no gender*, and *genderqueer/gender fluid*. Because of category sizes, *trans woman* and *woman* were collapsed to a *transfeminine* category, *trans man* and *man* were collapsed to a *transmasculine* category, and *agender/no gender* and *genderqueer/gender fluid* were collapsed into a combined *nonbinary* category. *Transgender* remained its own category. Sexual orientation response options included *lesbian/gay/same gender loving* (LGSGL), *heterosexual, queer, bisexual or pansexual*, and *not sure/questioning*. Age was originally collected as a categorical variable (*Under 18, 18 to 24, 25 to 34, 35 to 44, 45 to 54, 55 to 64, 65 to 74*, and *75 or older*). Due to sample size in each category and power concerns, these were recoded to the following categories: *Under* 25 (there were no respondents under 18), *25–44, 45–64*, and *65+*. Highest level of education completed was recoded into four categories (*some high school/high school/GED, associate's/some college, bachelor's degree*, and *postgraduate degree*).

Participants were asked whether they felt that their primary health care provider, or the provider that they saw the most often, offered them transgender-inclusive health care, with the response options of *yes* or *no*. They were asked whether they had ever taken hormones/HRT (response options of *yes* or *no)*, whether they had already had any sort of gender-affirming surgery (response options of *yes* or *no*), what types of surgeries they may have had, and if they wanted to begin or continue taking hormones/HRT in the future (response options of *yes* or *no)*. Responses to these four questions were combined to form a variable indicating whether the respondent had any type of transition-related medical intervention. They were asked whether they had ever delayed accessing care for any reason (response options *yes* or *no*), and if they answered in the affirmative, a variety of reasons for why they may have delayed care, including whether they delayed care due to fear of discrimination (response options *yes* or *no*).

Data analysis

Data were first examined for missing responses. The original sample included 417 participants, however due to lack of convergence in the imputation model, one record was dropped, leaving a final analytic sample of 416. Missing responses ranged from 0.24% for age to 11.27% for the dependent variable, *delayed care due to fear of discrimination*. All variables included in the analysis were imputed using multiple imputation with chained equations (van Buuren, Boshuizen, & Knook, 1999). The data analyses included descriptive statistics and two logistic regression models predicting delayed care due to fear of discrimination and having any medical intervention in order to understand the importance of transgender-inclusive care and other differential experiences across gender identity and sexual orientation.

Results

Descriptive characteristics of sample

Descriptive statistics provided in Table 1 were run using the multiply imputed data. The majority of respondents reported they had access to

Table 1. Descriptive statistics for all variables.

Variables			
Dependent Variables		*n*	%
Delayed Care	No	290	69.62
	Yes	126	30.38
Medical Intervention	No	121	28.98
	Yes	295	71.02
Independent Variables			
Transgender-Inclusive Care	No	164	39.35
	Yes	252	60.65
Gender Identity	Transmasculine	127	30.64
	Transfeminine	188	45.28
	Transgender	19	4.63
	Nonbinary	81	19.46
Sexual Orientation	Lesbian/Gay/Same Gender Loving	89	21.45
	Straight/Heterosexual	58	13.87
	Queer	97	23.39
	Bisexual/Pansexual	147	35.35
	Not Sure/Questioning	25	5.94
Race	White	352	84.63
	People of Color	64	15.37
Highest Level of Education	Some HS/Diploma/GED	50	11.91
	Some College/Tech/Associate's	171	41.20
	Bachelor's	114	27.34
	Graduate	81	19.54
Age	Under 25	93	22.36
	25 to 44	204	49.04
	45 to 64	102	24.52
	65+	17	4.09

transgender-inclusive health care (60.7%, n = 252). In terms of demographics, a large percentage of participants identified as transfeminine (45.4%, n = 188), bisexual/pansexual (35.4%, n = 147), White (84.6%, n = 352), having some college (41.2%, n = 171), and between 25 and 44 years of age (49.0%, n = 204). For the dependent variables 69.9% (n = 290) indicated they had not delayed care for fear of discrimination while 71.0% (n = 295) reported they had access to health care that was inclusive. Please see Table 1 for more details.

Delaying care due to fear of discrimination regression

In the first logistic regression (Table 2, Regression 1), controlling for all other variables, having a transgender-inclusive provider was associated with a 57% (AOR = 0.43, 95% CI [0.26, 0.74]) decrease in the odds of having delayed medical care due to fear of discrimination. Compared to transfeminine respondents, respondents who identified as transmasculine were almost two times as likely (AOR = 1.94, 95% CI [1.01, 3.73]) to report delaying care due to fear of discrimination while respondents who identified as nonbinary were 25% (AOR = 0.75, 95% CI [0.33, 1.71]) less likely to report delaying care due to fear of discrimination. Respondents who identified as queer were four times as likely (AOR = 4.19, 95% CI [1.65, 10.62]) to report a delay in care compared to their heterosexual peers. Respondents who were in the 45 to

Table 2. Logistic regressions.

Variable	Regression 1 Delayed Care N = 416	Regression 2 Any Medical Intervention N = 416
Transgender-Inclusive Care	0.43 [0.26, 0.74]**	7.72 [4.29, 13.90]***
Gender (Transfeminine)		
Transmasculine	1.94 [1.01, 3.73]*	1.15 [0.54, 2.43]
Transgender	0.98 [0.27, 3.62]	0.85 [0.21, 3.53]
Nonbinary	0.75 [0.33, 1.71]**	0.08 [0.03, 0.18]***
Sexual Orientation (Heterosexual)		
LGSGL	1.77 [0.68, 4.59]	0.31 [0.10, 0.92]*
Queer	4.19 [1.65, 10.62]**	0.85 [0.28, 2.65]
Bisexual/Pansexual	1.57 [0.63, 3.93]	0.64 [0.23, 1.77]
Not Sure/Questioning	0.62 [0.12, 3.29]	0.27 [0.06, 1.21]
POC (White – - 1 = POC, 0, White)	1.65 [0.86, 3.15]	0.82 [0.39, 1.75]
Level of Education (Some HS/Diploma/GED)		
Some College/Tech/Associates	2.16 [0.89, 5.25]	1.03 [0.42, 2.50]
Bachelors	1.80 [0.68, 4.78]	0.90 [0.34, 2.41]
Graduate Degree	1.56 [0.53, 4.63]	01.42 [0.47, 4.36]
Age (Under 25)		
25–44	0.87 [0.47, 1.60]	2.66 [1.29, 5.47]**
45–64	0.37 [0.16, 0.84]*	3.97 [1.63, 9.70]**
65+	0.60 [0.11, 3.27]	3.91 [0.66, 23.16]

Note: Odds ratios are adjusted for the other predictors in the model. * $p < .05$, ** $p < .01$, *** $p \leq .001$

64 year age range were 63% (AOR = 0.37, 95% CI [0.16, 0.84]) less likely to report delaying care due to fears of discrimination compared to respondents who were 25 years old or younger. There were no significant differences for race or education status.

Any medical intervention regression

In the next regression (Table 2, Regression 2), respondents reporting a transgender-inclusive provider were almost 8 times as likely (AOR = 7.72, 95% CI [4.29, 13.90]) to report having any medical intervention compared to those without inclusive providers. Compared to transfeminine respondents, nonbinary respondents were 92% (AOR = 0.08, 95% CI [0.03, 0.18]) less likely to have any medical intervention. Respondents who identified as LGSGL were 69% (AOR = 0.31, 95% CI [0.10, 0.92]) less likely to report any medical intervention compared to their heterosexual peers. Respondents who were in the 25 to 44 year age range were almost three times as likely (AOR = 2.66, 95% CI [1.29, 5.47]), to report medical intervention while those in the 45 to 64 age range were almost 4 times as likely (AOR = 3.97, 95% CI [1.63, 9.70]) to report any medical intervention compared to respondents who were 25 years old or younger. There were no significant differences for race or education status.

Discussion & implications

When it comes to sociodemographic factors, significant differences across gender identity, sexual orientation, and age emerged. There were, however, no significant differences across race or education status. This suggests that not only are their nuanced experiences within the TNB community across gender identities, but also that there is a need for a better understanding of the intersection between gender identity and other identities. Currently, there is little research exploring this intersection, as most extant research places all TNB into one group or focuses specifically on transfeminine individuals.

It is clear from these findings that TNB individuals have different experiences and face unique challenges when it comes to health care. One common narrative about the TNB community by the general public and providers not experienced with the community is that everyone wants to have a medical intervention as part of their transition (Lindroth, 2016), while another belief by those inexperienced with this population is that nonbinary individuals do not want to have any transition-related medical interventions (Lykens, LeBlanc, & Bockting, 2018). Our results suggest that is not the case as medical intervention experiences varied across gender identities, with no single gender identity group reporting 100% as either having a medical intervention or not having a medical intervention. However, nonbinary respondents had much lower rates of medical interventions. Some of this

may be due to choice and not wanting to transition to a specific binary gender. However, some nonbinary individuals have also had challenges in medical spaces when attempting to access HRT and surgeries, including being viewed as "not trans enough" and providers unfamiliar with how to support nonbinary patients with medical interventions (Vincent, 2019).

Health care professionals need to connect with their patients on an individual level regarding what (if any) medical interventions they desire, rather than making assumptions about what their patients desire as part of their transition. This concept of self-determination (being able to individually decide what it means to be TNB and what they would like to happen to their bodies) is in line with the National Association of Social Workers' Code of Ethics (National Association of Social Workers, 2008). Social workers should support their clients in making their own decisions about their bodies. To do this, those working with TNB clients, in either clinical or health care settings, should familiarize themselves with resources in their area (including providers known to be trans-affirming), attend CE courses regarding trans-inclusive practices, provide information to their TNB clients about options regarding a variety of medical interventions, and help to support inclusive environments, including advocating for trans affirming intake forms, use of correct name and pronouns, gender inclusive restrooms, etc.

Transmasculine participants were almost twice as likely to delay needed medical care due to fear of discrimination compared to transfeminine individuals. This may be due to more negative cultural stereotype about transgender men and lesser knowledge about transmasculine individuals (Gazzola & Morrison, 2014), even though transfeminine individuals of color are most likely to experience physical violence (Hudson, 2019; James et al., 2016). On the other hand, those who reported having a trans-inclusive PCP were significantly less likely, by more than half, to delay care due to this fear. These findings reinforce not only the need for affirming and inclusive providers, but also for recognizing that different groups in the community may have unique barriers that need to be addressed. Queer-identified individuals were more than four times more likely to delay care for fear than their heterosexual counterparts. Given how little health research there is on specifically on transmasculine individuals [as many health related studies combine men who have sex with men with transfeminine individuals, leaving out transmasculine individuals], queer individuals, and their health care experiences, this area needs further research to understand more about this fear and work with both providers and patients to create more inclusive health care spaces. It also indicates the need for more inclusive language options in research, as the "Q" is often left out of selections options under sexual orientation, despite this study showing respondents with this identity having different experiences that those with other sexual orientation identities.

Those under 25 were significantly less likely to have had any medical intervention, which may either be a result of older individuals having had more time throughout their lifetime to have had an intervention or having greater access to resources to undergo an intervention. LGSGL individuals were more than two thirds less likely to have had any medical intervention than heterosexual participants; this could be a reflection different experiences of body image than in heterosexual communities (Huxley, Halliwell, & Clarke, 2015), of a focus on differential sexual activities outside of penetrative intercourse, or multiply marginalized identities meaning less access to resources, although more research is needed to better understand why these differences exist. The biggest difference around medical intervention was that those who have a trans-inclusive PCP were almost eight times more likely to have a medical intervention as compared to those who didn't have a trans-inclusive PCP. It should be noted that it is possibly due to people who wanted trans-specific medical interventions being more likely to seek out trans-inclusive PCPs as compared to their counterparts who did not desire such an intervention. With approximately 40% of the sample reporting not having a trans-inclusive PCP, there is need for more research on the lack of inclusive providers, the challenges members of this community face when trying to access a trans-inclusive provider, and on best practices for helping existing providers be more knowledgeable about and inclusive of the TNB population, especially those who identify as nonbinary.

Just as TNB individuals were shown to have different experiences across gender identities, so too are there differing experiences across sexual orientation. Culturally-responsive providers should also be aware of these differences, and further research is needed to explore these differences across sexual orientation within the TNB community. Social workers can support both their own teams, and providers as a whole in learning how to provide trans-affirming health care and ensuring that all providers are prepared to address the variety of health issues faced by the TNB community. Additionally, health providers across all different disciplines should be able to access better and more nuanced training about the best way to support and serve their TNB patients in order to ensure not only access to needed care and medical interventions (if desired), but also to potentially lower the rate of those who delay access to care due to their fear of discrimination. Providers can find more concrete strategies and recommendations for inclusive practice in the existing literature (e.g., Puckett et al., 2018; Reisner et al., 2015; Torres et al., 2015), however, our results point to the critical need for individualizing treatment based on intersections of different identities within the TNB community. For example, our findings demonstrate an increased likelihood of transmasculine individuals delaying care than others in the TNB community, suggesting a need for targeted outreach efforts. This finding additionally suggests that providers may be more familiar and educated

about issues of transfeminine individuals, noting a need for additional education on the needs of others in the TNB community.

Limitations

This study has several limitations to consider. The use of single-item measures may have obscured potentially important nuances that may have been detected with the use of scaled instruments. Cross-sectional data do not allow for causal inferences and some variables may have bidirectional relationships which cannot be teased apart with cross-sectional data. While this study offers an initial intersectional examination of the experiences of TNB individuals, a more nuanced intersectional approach is needed. A more intersectional approach would require a more heterogeneous sample and additional variables would need to be included (e.g., disability, relationship status, country of citizenship, geographic location, outness, community support, family support, etc.). Perhaps a qualitative approach could be used to delve into the intersectional experiences of the transgender and nonbinary community.

Language accessibility may have been a concern. Participants may have skipped questions or ended the survey due to not understanding questions or feeling invalidated by the questions due to the language used. Also, in terms of asking about transgender-inclusive health care, people may interpret inclusive health care very differently. Some may interpret inclusion simply as a lack of discrimination while others may think of it as more comprehensive (e.g., the use of inclusive language, following best practices and emerging science on transgender/gender diverse medical needs). Although the survey was distributed both online and in-person, people living rurally or without Internet access, may have not had access to participate in the survey.

Finally, the sample was overwhelmingly White, resulting in the need to collapse other racial identities into one category. It is likely that TNB people of color have different experiences than their White peers, and across different racial groups. The fact that the sample sizes of people of color was so small may have led to a type II error, noting that there were no differences by race, when in fact, there may very well be differences. This issue was also apparent with the need to collapse these into only a few groups, due to such small sample sizes in each racial group. Similar issues may have occurred given the small sample size of agender/no gender and genderqueer/genderfluid individuals; while combining them is not ideal, having them as separate groups may have resulted in low power. This sample, while reflective of the racial makeup of the state in which the data was collected, does not mirror the overall racial breakdown of TNB population in the United States. This is a challenge with many data sets with this population, and researchers should highly consider oversampling TNB

individuals of color in order to be able to understand their nuanced experiences as members of this community.

Conclusion

Prioritization of trans-specific research that represents the diversity of unique experiences within the TNB community has been recommended, (IOM, 2011; Kcomt, 2019), particularly for addressing trans erasure in health care (Bauer et al., 2009). Although extant studies have focused on the need for more trans-inclusive health care practices for the TNB community as a whole, this study found that there are differential experiences and needs across gender identity, sexual orientation, and age, even within the TNB community. Additionally, the finding that having a trans-inclusive provider is significantly related to not delaying needed health care due to fear is one that underscores the importance of supporting the health needs of this community. Social workers who are part of the health system can help contribute to change by ensuring both they and other providers are knowledgeable about issues facing the TNB community, and providing trans-affirming care. By supporting providers to better understand the medical needs of this diverse population, there is an opportunity to increase access to care, and reduce the number of patients delaying their medical care due to fear. More culturally responsive providers may lead to better health outcomes for the TNB community; a positive outcome for all those involved in health care.

Conflict of interest

The authors have nothing to declare.

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